CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 25, 2002

H.R. 4600
Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2002

As ordered reported by the House Committee on Energy and Commerce on September 19, 2002

SUMMARY

H.R. 4600 would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, reducing the statute of limitations, eliminating joint and several liability, and changing the way collateral-source benefits are treated.

Those changes would lower the cost of malpractice insurance for physicians, hospitals, and other health care providers and organizations. That reduction in insurance costs would, in turn, lead to lower charges for health care services and procedures, and ultimately, to a decrease in rates for health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and fringe benefits. As a result, CBO estimates that enacting H.R. 4600 would increase federal revenues by $40 million in 2003 and by $2.4 billion over the 2003-2012 period.

Enacting H.R. 4600 also would reduce federal direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, and other federal health benefits programs. CBO estimates that direct spending would decline by $11.3 billion over the 2004-2012 period. Because the bill would affect revenues and direct spending, pay-as-you-go procedures would apply.

Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 4600 would reduce discretionary spending for the FEHB program by about $400 million over the 2004-2012 period.

The bill would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for damages). That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). Such a preemption would limit the application of state law, but it would require no action by states that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($58 million in 2002, adjusted annually for inflation) would not be exceeded.

H.R. 4600 would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation) in each of the first five years the mandate would be effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4600 is shown in the following table. The effects of this legislation on direct spending fall within budget functions 550 (health) and 570 (Medicare). The effects on spending subject to appropriation fall within multiple budget functions.

	By Fiscal Year, in Millions of Dollars										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003 - 2012
CHANGES IN REVENUES											
Income and HI Payroll Taxes (on-budget)	30	80	130	160	170	180	190	210	240	260	1,650
Social Security Payroll Taxes (off-budget)	10	30	60	70	80	90	90	100	110	110	750
Total	40	110	190	230	250	270	280	310	350	370	2,400
CHANGES IN DIRECT SPENDING											
Estimated Budget Authority	0	-250	-390	-690	-1,220	-1,520	-1,660	-1,770	-1,880	-1,920	-11,300
Estimated Outlays	0	-250	-390	-690	-1,220	-1,520	-1,660	-1,770	-1,880	-1,920	-11,300
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Estimated Authorization Level	0	-20	-40	-40	-40	-50	-50	-50	-50	-60	-400
Estimated Outlays	0	-20	-40	-40	-40	-50	-50	-50	-50	-60	-400

NOTE: HI = Medicare Hospital Insurance program.

BASIS OF ESTIMATE

This estimate assumes that H.R. 4600 will be enacted in October 2002. It would apply to lawsuits initiated on or after the date of enactment.

Major Provisions of the Bill

H.R. 4600 would place caps on awards by limiting non-economic damages, such as pain and suffering, to $250,000, and punitive damages to twice the amount of economic damages or $250,000, whichever is greater. Punitive damages would be further constrained by limiting the circumstances under which they may be sought. Economic, or compensatory, damages would not be limited. Attorney fees would be restricted as follows: 40 percent of the first $50,000 of the award, 33.3 percent of the next $50,000 of the award, 25 percent of the next $500,000, and 15 percent of that portion of the award in excess of $600,000. The caps on attorney fees would apply regardless of whether the award was determined in the courts or settled privately, and could be reduced further at the discretion of the court. (The court could not, however, increase attorney fees beyond the caps.) For awards of future damages equal to or exceeding $50,000, any party to the lawsuit could request that future damages be paid by periodic payments.

The bill would impose a statute of limitations requiring that lawsuits begin within three years after the injury alleged to have happened as a result of malpractice occurs or one year after the claimant discovers, or should have discovered, the injury, whichever occurs first. Under the joint and several liability provisions of current law, defendants found negligent in a lawsuit are each liable for the full amount of damages, regardless of their proportionate share of responsibility for the injury. H.R. 4600 would limit the liability of each defendant to the share of damages attributable to his or her responsibility.

Collateral-source benefits are other sources of compensation a claimant may have access to in the event of an injury. A common source of such benefits is the claimant's health insurance, which would likely pay for a portion of the medical costs arising from the injury. Other sources include disability insurance payments, workers' compensation, and life insurance payments. The bill would allow evidence of such benefits to be introduced at trial by either claimants or defendants. In addition, providers of collateral-source benefits would not be allowed to place a lien on the claimant's award or recover any amount from the claimant, whether or not the case goes to trial.

Impact on Medical Malpractice Insurance Premiums

CBO's estimate of the impact of this bill is based on a statistical analysis of historical premiums for medical malpractice insurance coverage in states that have and have not enacted medical malpractice tort limitations. We conducted another analysis using medical malpractice claims data provided by the Physician Insurers Association of America. CBO also considered the impact of factors not directly related to trends in malpractice claim payments that may have contributed to recent increases in medical malpractice premiums. Those factors include reduced investment income of insurers, the need of insurers to replenish depleted reserves, and recent increases in reinsurance costs for all types of insurance.

CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law. That effect would increase somewhat over the ten-year time horizon of this estimate because caps on awards would not be indexed to increase with inflation. As a result, the caps on awards would become more constraining in later years.

CBO estimates that, under this bill, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law. However, other factors discussed above may exert upward pressure on future premiums, possibly obscuring at least some of the anticipated effect of the legislation. The effect of H.R. 4600 would vary substantially across states, depending on the extent to which a state already limits malpractice litigation. There would be almost no effect on malpractice premiums in about one-quarter of the states, while reductions in premiums would be substantially larger than the overall average in about one-third of the states.

Impact on Health Insurance Premiums

The percentage effect of H.R. 4600 on overall health insurance premiums would be far smaller than the percentage impact on medical malpractice insurance premiums. Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance. Because providers of collateral-source benefits would be prevented from

recovering their costs arising from the malpractice injury, some of the costs that would be borne by malpractice insurance under current law would instead be borne by the providers of collateral-source benefits. Most such providers are health insurers.

CBO's estimate does not include savings from reductions in the practice of defensive medicine—services and procedures that are provided largely or entirely to avoid potential liability. Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.

Nonetheless, while there is insufficient evidence to justify including a defensive medicine adjustment in the estimate, the promising nature of the studies' results merits further analysis. CBO has obtained a person-based longitudinal database that contains detailed claims information on Medicare spending for covered services used by a random sample of fee-for-service beneficiaries between 1989 and 1997. Using these data, CBO hopes to expand the analysis of earlier researchers to include broader measures of spending (including hospital services, physician care, post-acute care, and ancillary services) and a larger number of conditions, to help determine the extent to which the results of the earlier studies may apply to overall health care spending.

Federal Revenues

CBO estimates that, over a three-year period, enacting H.R. 4600 would lower the price employers, state and local governments, and individuals pay for health insurance by about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the lower premiums. Those responses would include an increase in the number of employers offering insurance to their employees and in the number of employees enrolling in

employer-sponsored insurance, changes in the types of health plans that are offered, and increases in the scope or generosity of health insurance benefits. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on the total costs of health plans.

The remaining 40 percent of the potential reduction in premium costs, or about 0.2 percent of group health insurance premiums, would occur in the form of lower spending for health insurance. Those savings would be passed through to workers, increasing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that savings would ultimately be passed through to workers. We assume that state, local, and tribal governments would absorb 75 percent of the decrease and would increase their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the decrease. CBO estimates that the resulting increase in taxable income would grow from $126 million in calendar year 2003 to $1.1 billion in 2012.

Those increases in workers' taxable compensation would lead to more federal tax revenues. The estimate assumes an average marginal rate of about 20 percent for income taxes and the current-law rates for the Hospital Insurance and Social Security payroll taxes (2.9 percent and 12.4 percent, respectively). CBO further assumes that 15 percent of the change in taxable compensation would not be subject to the Social Security payroll tax. As a result, we estimate that federal tax revenues would increase by $40 million in 2003 and by a total of $2.4 billion over the 2003-2012 period if H.R. 4600 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals.

Federal Spending

CBO estimates that H.R. 4600 would reduce direct spending for federal health insurance programs by $11.3 billion over the 2004-2012 period. Those totals reflect reductions in spending resulting from the effect of lower premiums for malpractice insurance, partially offset by increases in direct spending because federal programs could no longer collect collateral-source benefits.

CBO estimates that premiums for the Federal Employees Health Benefits (FEHB) program would decline by the same 0.4 percent as the estimated average change in premiums for private health insurance. (That estimate includes the effects of H.R. 4600 on both premiums for malpractice insurance and the collection of collateral-source benefits.) We assume that participants in the FEHB program would offset 60 percent of that reduction by choosing more expensive plans, so that spending for the FEHB program would decline by about 0.2 percent. The 2003 premiums for FEHB plans have already been announced, so there would be no effect on FEHB spending in 2003.

Federal spending for annuitants in the FEHB program is considered direct spending. CBO estimates that H.R. 4600 would reduce direct spending for annuitants in FEHB by $270 million over the 2004-2012 period. Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 4600 would reduce discretionary spending for FEHB by about $400 million over the 2004-2012 period. Spending for postal workers and postal annuitants participating in the FEHB program is off-budget. CBO estimates that changes in spending for Postal Service participants would be offset by changes in the prices of postal services, and therefore would net to zero.

Each year, the Centers for Medicare & Medicaid Services sets Medicare payment rates for physician services and hospital services that include explicit adjustments for changes in the cost of malpractice premiums. CBO estimates that H.R. 4600 would have no effect on Medicare spending in 2003, because payment rates have already been set for hospital services and will be set for physician services before the effects of the bill could be incorporated in the rate-setting process. CBO estimates that incorporating lower malpractice premiums in Medicare payment rates would reduce Medicare spending by $10.8 billion over the 2004-2012 period.

CBO assumes that the rates that state Medicaid programs pay for hospital and physician services would change in proportion to the changes in Medicare payments. In addition, lower Medicare payment rates would result in lower payments by beneficiaries for cost sharing and premiums. Therefore, H.R. 4600 would reduce spending by federal programs that pay premiums and cost sharing for certain Medicare beneficiaries—Medicaid and the Tricare for Life program of the Department of Defense (DoD). CBO estimates that H.R. 4600 would reduce direct spending for Medicaid and DoD by $3.6 billion over the 2004-2012 period.

Under current law, Medicare and Medicaid pay the medical costs arising from medical malpractice injuries. In the event that a patient wins a settlement, the programs require reimbursement for the costs they incurred. H.R. 4600 would prohibit Medicare and Medicaid from making any future collections. CBO estimates that implementing this provision would increase outlays by $3.4 billion over the 2004-2012 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By Fiscal Year, in Millions of Dollars										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in receipts	0	30	80	130	160	170	180	190	210	240	260
Changes in outlays	0	0	-250	-390	-690	-1,220	-1,520	-1,660	-1,770	-1,880	-1,920

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACTS

The Unfunded Mandates Reform Act defines a mandate as legislation that "would impose an enforceable duty" upon the private sector or a state, local, or tribal government. CBO believes that UMRA's definition of a mandate does not include legislation that would, for example, impose requirements or limitations on recoveries, address burdens of proof, or modify evidentiary rules because such changes would be methods of enforcing existing duties, rather than new duties themselves as contemplated by UMRA. The provisions of H.R. 4600 would not impose or change the underlying enforceable duties or standards of care applicable to those providing medical items and services under current law. Rather, they would address the enforcement of existing standards of professional behavior through tort litigation procedures.

Clearly, a cap on recoveries of damages from medical malpractice would lower recoveries by future plaintiffs while reducing the costs borne by potential defendants. This cost effect, however, would not itself establish a new mandate. It would be more reasonably viewed as part of the process for enforcing the professional duties of medical providers, rather than an enforceable duty as defined by UMRA.

Intergovernmental Mandates and Other Public-Sector Impacts

Intergovernmental Mandates. The bill would preempt state laws that would prevent the application of any provisions of the bill, but it would not preempt any state law that provides greater protections for health care providers and organizations from liability, loss, or damages. Those that provide a lesser degree of protection would be preempted. (State laws governing damage awards would not be preempted, regardless of whether they were higher or lower than the caps provided for in the bill.) These preemptions would limit the application of state law, but they would require no action by states that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($58 million in 2002, adjusted annually for inflation) would not be exceeded.

Other Public-Sector Impacts. State, local, and tribal governments would realize net savings as a result of provisions of H.R. 4600. State, local, and tribal governments that assess income taxes also would realize increased tax revenues as a result of increases in workers' taxable income. CBO has not estimated the magnitude of those increased revenues.

State, local, and tribal governments would save money as a result of lower health insurance premiums precipitated by the bill. Based on information from the Bureau of the Census and the Joint Committee on Taxation and on our estimates of the effect of the bill on health care premiums, CBO estimates that state and local governments would save about $5 billion over the 2003-2012 period as a result of lower premiums for health care benefits they provide to their employees. That figure is based on estimates of state and local spending for health care growing from about $95 billion in 2003 to $189 billion in 2012 and an expectation that savings would phase in over a three-year period. The estimate accounts for some loss in receipts because state health, sickness, income-disability, accident, and workers' compensation programs would no longer be able to recover a share of malpractice damage awards.

State and local governments also would save Medicaid costs as a result of lower health care spending. CBO estimates that state Medicaid spending would decrease by about $2 billion over the 2003-2012 period.

Private-Sector Mandates and Other Impacts

The bill would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate to affected attorneys would amount to about $140 million in 2003, rising to about $320 million in 2007. Those costs would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation) in each of the first five years the mandate would be effective.

PREVIOUS CBO ESTIMATE

On September 24, 2002, CBO produced a cost estimate for H.R. 4600 as ordered reported by the House Committee on the Judiciary on September 10, 2002. The two bills are identical with the exception of a minor difference in the set of exceptions to the statute of limitations. That difference does not effect CBO's estimate of the impact of the bill on premiums for health insurance, on federal revenues and spending, on state, local, or tribal governments, or on the private sector.

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